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ABSTRACT

A comprehensive developmental screening model (CDSM) was designed to help local education agencies (LEAs), in Indiana, plan, develop, and implement screening programs for 3-, 4-, and 5-year-old children. The CDSM is presented in three parts: Part I provides both empirical and philosophical support to the reasons for developing a screening program; Part II addresses individual components of the screening process for planning through instrument selection to implementation and method of delivery; and Part III provides some guidelines to assist the screening coordinators involved in actual implementation of the screening procedure. To validate the usefulness of the CDSM, three LEAs were selected to pilot-test the procedures. Four criteria were considered in selecting these pilot sites: geographic location; diversity of population; size of population; and local need and interest. Summary of the pilot sites screening programs along with some recommendations based on evaluating the administration of the total program and the implementation procedure of the pilot sites, are presented in Appendix D. Other appendices include instrument reviews and summary charts, a list of participating organizations, parent communications and references. (Author/MP)

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INDIANA PRESCHOOL SCREENING PROGRAM

Indiana Department of Public Instruction
Harold H. Negley, Superintendent

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Commitment from these people and the dedicated staff of the Indianapolis Public Schools has made this project a fantastic experience for me and the children who will benefit from the program. I hope what this program has started will continue to develop and grow. The primary phase has been completed. The real work begins now.

--Joseph Leuer

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COMPREHENSIVE DEVELOPMENTAL SCREENING MODEL



Division of Special Education

Indiana Department of Public Instruction
Harold H. Negley, Superintendent

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INTRODUCTION

Public Law 90-538, Handicapped Children's Early Assistance Act, brought to the forefront the need for a free, appropriate public education for all children and the need to develop identification systems for children with special needs. On September 30, 1968, President Johnson, in signing the Early Assistance Act, remarked:

This Act will provide 70 to 100 model educational centers for the handicapped. The centers will give an important boost to preschool education for the handicapped. And they will be a spur to local and state agencies to improve their programs for the handicapped. Most important, these new centers will bring hope to families and children who very much need — and deserve — our help ...

No one can doubt the value or wisdom of this law ...

It gives me pleasure to think about the good it will do: the lives it will touch ...

Almost a decade later, Public Law 90-538 was enhanced and expanded when President Ford signed The Education for All Handicapped Children Act of 1975, P.L. 94-142. Among other provisions, this law stipulates each state will develop a plan for identifying, locating, and evaluating all children in that state who are handicapped, and each state will develop a practical method for identifying served and unserved handicapped children under existing programs.

Although these two pieces of legislation have been enacted within recent years, the roots of the laws lie in the White House Conference on Children in a Democracy, held in 1940. From this conference the following



educational recommendations were made:

Schools should give increased attention to the educational needs of individual children, including those who are physically handicapped, mentally retarded, or socially handicapped. These needs should be met with minimum emphasis on the handicap ...

School systems should provide nursery school, kindergarten, or similar educational opportunities for children between the ages of 3 and 6.

How does today's educational system compare to the 1940 White House Conference recommendations? Public Law 94-142 and Indiana's Rule S-1 have brought the present educational system much closer to those goals recommended in 1940.

Legislative history has provided a basis for the inception of "The Indiana Preschool Screening Project". This project, funded by the Bureau of Education for the Handicapped through a Preschool Incentive Grant, is designed to aid Local Education Agencies (LEA's) in planning, developing, and implementing preschool screening programs for children 3, 4, and 5 years of age.

Public Law 94-142 indicates five essential components to effective programming:

1. Casefinding
2. Screening
3. Diagnosing
4. Educational Assessing
5. Program Evaluating

This manual addresses the screening component for preschool children. As such, the major project objectives include:

The design of a comprehensive developmental model for screening



3-, 4-, and 5-year-old children ...

The development of workshops for LEA administrators throughout the state. The purpose of these workshops is for sharing information and disseminating materials regarding the development of preschool screening programs.

The model described herein was developed for LEA's in Indiana to help them establish screening programs for children between 3 and 5 years of age. To accommodate the diversity of populations served by the LEA's in this State and the diversity of needs within each school corporation, a flexible method for screening has been developed to allow local agencies to adopt a program with appropriate content to respond to community differences. The model is called The Comprehensive Developmental Screening Model.

The Comprehensive Developmental Screening Model has three decision points: Part I - To Screen or Not to Screen; Part II - Planning for Screening; and Part III - Implementing the Screening Process.

Part I provides background information relative to the reasons for a screening program.

Part II addresses individual components of the screening process from planning through instrument selection to implementation.

Part III provides information/guidelines to assist those persons involved in the actual implementation of a screening procedure.

To validate the usefulness of the information provided within the Comprehensive Developmental Screening Manual, three LEA's were selected



to pilot-test the procedures. In selecting the pilot sites the following criteria were considered:

- Geographic location
- Diversity of population
- Size of population
- Local need and interest

The material in this manual is provided as a resource: a starting point for those agencies becoming involved in the preschool screening process and for those persons implementing identification services.



PART I: TO SCREEN OR NOT TO SCREEN: A RATIONALE

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The issue of early identification of developmental strengths and weaknesses in young children has received wide-spread attention and consideration recently in professional journals as well as in the popular press. Educators have witnessed a major transformation in thinking concerning early identification, screening, and programming for exceptional children. Attitudes toward services for the handicapped have evolved from a "forget and hide" approach to a "screen and segregate" approach to the present attitude of "identify and help" (Caldwell, 1973). Wolfensberger (1965), over a decade ago, shed considerable light on the subject of early identification:

Early diagnosis is desirable when it leads to prevention, early treatment, or constructive counseling; it is irrelevant if it is purely academic and does not change the course of events; it is harmful if, in balance, child or family reaps more disadvantages than benefits (p. 65).

The resurgence of interest in the area of early screening has been largely brought about by legislative mandate. Several significant pieces of legislation have stimulated this renewed interest.

Title XIX, Section 1905 (a) (4) (B), a 1967 amendment to the Social Security Act which became effective July 1, 1969 required:

...such early and periodic screening and diagnosis of individuals



who are eligible under the plan or are under the age of 21 to ascertain their physical and mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby as may be provided in regulations of the Secretary.

The Early and Periodic Screening, Diagnosis, and Treatment Program (E.P.S.D.T.) became a mandated service under the Medicaid Program—a public health care delivery system.

Public Law 94-142, The Education for All Handicapped Children Act was passed in 1975. The Rules and Regulations for the implementation of that Act require that:

...all children who are handicapped, regardless of the severity of their handicaps, and who are in need of special education and related services are identified, located, and evaluated (Section 121 (a) (128).

As defined under the category of Related Services, "Early identification means the implementation of a formal plan for identifying a disability as early as possible in a child's life" [Section 121 (a. 13) (vi) (3)].

Title V of the Rehabilitation Act of 1973 (Public Law 93-112) guarantees the civil rights of individuals with disabilities. Although this law was passed in 1973, its regulations did not go into effect until June, 1977. Section 504 of Title V incorporates the language of Titles VI and IX of the 1964 Civil Rights Act, which guarantees equal treatment of racial minorities and women, in order to extend those guarantees to all handicapped persons. Section 504 specifically states:

No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of,



or be subjected to discrimination under, any program or activity receiving Federal financial assistance.

The State of Indiana, in compliance with the Federal Statute (Public Law 94-142), stipulates in Section IX (Case Find) of Rule S-1 that:

Each school shall insure that all handicapped children, age birth through twenty-one (21), residing within the jurisdiction of the school, including those in public and private agencies and institutions, regardless of the severity of their handicap, who are in need of special education and related services are identified, located, and evaluated.

In addition:

...such procedures are on-going and are conceptualized with: awareness, initial identification and location, diagnosis/evaluation, service delivery, and periodic reassessment.

The aforementioned legislation clearly reflects the attitude that early identification is fundamental to the development of appropriate non-discriminatory educational programs for special needs learners.

The purpose of a community-wide systematic developmental screening program is to identify children while they are young and most amenable to educational intervention programs. As Jensen (1967) has stated:

Our present knowledge of the development of learning abilities indicates that the preschool years are the most important years of learning in the child's life . . . and this learning is the foundation for all further learning (p. 125).

There is considerable agreement among professional educators as to the critical importance of early identification of developmental difficulties and handicapping conditions (Adelman & Feshback, 1971; Gallagher & Bradley, 1972; Zehrbach, 1975). The advantage of early identification and diagnosis is that the prevention or reduction of future developmental

complications is made possible through remediation and/or enrichment programs. The focus of identification or early developmental screening is not just to document or confirm developmental deficits, but also to provide relevant information which might be used as the basis for preventing or reducing later problems. Weikart (1971), in discussing the impact of early detection and appropriate intervention, points out that early help for a child may make it possible for that child to move into regular educational programs earlier than the child who receives no "early" assistance.

Investment in a cost-effective systematic community-wide developmental screening program could pay increased personal, educational, and societal dividends.

Many early intervention programs have had the benefit of early diagnosis of developmental disabilities (Bricker & Bricker, 1973; Caldwell, 1970; Gray and Klaus, 1969; Hodges, McCandless and Spicker, 1971; Kirk, 1958). Results of these studies indicate that the cost of a developmental screening program would be very small compared to the saving in human functional competence. Considering the cost-benefit factors of early screening, Hobbs (1975) cites several research studies whose results suggest that long-term care of the handicapped may be reduced by early treatment programs. Special education programs generally are more expensive to operate than regular education programs because learning environments for special needs learners require higher adult-child ratios. A long-term benefit of early screening could be reduced expenses for special educational services.



The development of a community-wide systematic screening program can be meaningful to the Local Education Agencies if certain conditions can be met:

- if developmental screening is considered a systematic way to identify strengths and competencies as well as weaknesses and deficits.
- if developmental screening is used to assess present strengths and weaknesses and not to predict future potential. Predictability is not possible because of the lack of standardization data using different ethnic, socio-economic, and educational backgrounds of children and because of the small number of items traditionally contained in such screening devices.
- if the screening process is considered a "means" to an educational end, rather than an "end" in itself. A "one-shot" attempt to identify abilities or inabilities on a developmental parameter would be a flagrant violation of the principles of educational diagnosis and evaluation.
- if there is a conscious diligent effort exerted to limit attachment of labels or categorization of a child prior to a more comprehensive evaluation.
- if a criterion-references screening instrument is utilized which can locate the child's progress along a developmental continuum, describing capabilities and limitations for which some form of intervention can be prescribed.
- if appropriate intervention (remediation or enrichment) follow-up programs are designed, implemented, and evaluated only after comprehensive diagnostic study.

The information presented in this section lends both empirical and philosophical support for early developmental screening. Before adopting an early screening program, a Local Educational Agency will need to evaluate its own present organizational and administrative capacities (in terms of financial, personnel, and community resources) to deliver a community-wide developmental screening program which is both systematic and cost-effective.



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PART II: PLANNING FOR SCREENING

A. OVERVIEW

Careful planning of the screening program by individuals of the school corporation, in conjunction with interested professionals and other community members (including parents) will assure maximum success of the screening program. An integral part of the planning process is an understanding by the planners of preschool screening and the benefits which may be derived from it.

Screening is a prerequisite for educational program planning. Administrators, teachers, and children benefit from information obtained in the screening process. Screening information may be used for developing staffing patterns, special programs, and budgetary items. Program projections may be based on data collected about the children identified through screening. Advance information of children's learning needs may also help teachers in developing appropriate curricula and materials.

Screening is a technique for identification of "high risk" children, i.e., children who might be expected to experience some failure in school. These children may benefit from special services early in their educational careers: Early intervention may be one means of furthering their chances for educational success.



Screening is a means of providing feedback to parents. For many parents, this might be the first time educational feedback about their children has been shared with them. This feedback will usually be positive, thus making their first contact (if it is their first child) a positive experience. This can help with community relations.

If parents are told their child needs further evaluation or extra help in a particular modality, fears are usually relieved. In many cases, parents already suspect the child is delayed and welcome the help which will be given.

The following questions and answers address some of the concerns of those persons considering implementing a screening program:

What is screening?

Screening is a procedure for identifying those children who may need further evaluation to determine specific educational needs. It is a short procedure which considers individual performance. The information derived through this process may be used in any of several ways: to identify those children who need further evaluation, to plan appropriate curricula and to define staff personnel needs.

Why screen preschool children?

The U.S. Offices of Education, Child Development, and Social and Rehabilitative Services have issued mandates for large-scale early identification and program implementation procedures.

Screening is an essential component of Early Identification (Child Find) and a step toward appropriate program development. The earlier a child with special needs is identified, the earlier he or she may be appropriately served.



Why screen...(continued)

An appropriate educational setting will increase the probability a child will have a good educational and emotional experience in his/her first years of school.

Research in early childhood education indicates, as stated by Haring and Ridgeway (1967), "Failure to progress may be as much the fault of the learning environment as a function of the organism".

For the child who needs special help, it is critical his/her needs are identified early and education services are developed to meet those needs. Time is one factor over which society has little control, and yet is one of the most important variables in the education of special children.

Community-wide screening assists administrators and teachers in planning for the future needs of the school population.

Will screening identify only those children who need special services?

Due to inherent problems of screening methods and instruments, a significant percent of children identified may be considered "false positives". "False positives" are those children identified inappropriately as needing further diagnostic evaluation. Further observation and/or rescreening will negate false identification. Approximately 10% of the total screened population may be expected to need further evaluation.

Can a child be placed directly into a special education program from screening?

Screening is an identification procedure. The information obtained during screening may be helpful in determining appropriate placement or planning remedial programs, but it is not sufficient alone to determine placement.



B. FORMATION OF THE PLANNING TEAM

Community support is necessary in developing a planning team. Individuals who know and understand the community are of great assistance in the planning endeavors. Planning team members may include:

Screening Coordinator:

This position requires a working knowledge of the legal aspects and procedures of P.L. 94-142 and Rule S-1. Preschool experience would aid the individual in making appropriate decisions, but is not necessarily a prerequisite. As preschool screening is a community-wide endeavor, the screening coordinator needs to possess public relations and organizational skills.

School-based Specialist:

Personnel from various educational disciplines have pertinent information regarding the school population and the needs of the school system. Specialists may provide expertise in the areas of planning, instrument selection, preservice training, evaluation, and follow-up. Specialists in the field of early childhood education, psychology, health, sociology, and speech and language development may be considered. As most screening instruments may be administered by paraprofessionals and/or volunteers, the actual screening service need not be rendered by the specialists.

Representatives of Community Agencies:

Personnel from agencies such as Head Start, Public Health Department, Visiting Nurses Association, Child Guidance Clinics, Association for Retarded Citizens,



Representatives...(continued)

Family Service Organizations, Day Nursery Associations, Indiana Society for Prevention of Blindness (who provide free vision screening and materials), and church organizations may already be working cooperatively with the local school in "Child Find" activities. Utilizing persons from these agencies provides the school system with information concerning other types of screening available in the community as well as sources of volunteers from which screening implementors may be drawn.

Parent Involvement:

Local PTO/PTA's and social groups are excellent resources for community support and volunteer help. For disseminating information and creating "grass roots" support, these parent organizations can be vital to the success of the screening program. They also are an integral part of the planning process, providing input on many important issues (parent expectations, feasibility of logistics, appropriateness of forms, reactions of children, etc.).



C INSTRUMENT SELECTION

1. Considerations

To select a reliable, cost effective screening instrument suitable to a given school corporation, planners should consider:

Cost of materials and personnel necessary to conduct screening:

Screening materials are usually inexpensive, once the initial screening kit has been purchased. Cost of commercial kits may range from \$2.00 for a specimen set to \$125.00 for a complete testing kit. Personnel salaries are the bulk of the screening cost. The use of paraprofessionals and volunteers to conduct the screening is one means of reducing cost.

Site Selection:

Available space in which screening will occur impacts instrument selection. If space is limited, instruments which require few persons for administration would be preferred.

Standardization, Validity, and Reliability:

To maintain the established validity and reliability of a given screening instrument, the target population must approximate the population on which the instrument was originally standardized. As such, not all screening instruments are appropriate for all populations.

Individually Administered Instruments:

If the screening process is designed to obtain maximum information in a limited amount of time, individually administered tests are preferred. For most individually administered tests, the parent should be present. The parent may offer additional information not generated through testing of the



Individually...
(continued)

child. Parent/child interaction may also elicit information important to the screener.

Developmental Areas
Screened:

School corporations will want to determine which developmental areas should be screened for their populations and select instrument(s) covering the required areas.

Instrument Selection:

Instrument selection will be unique to each LEA. Each LEA differs in its capacity and need to provide preschool screening. Each LEA serves a population with particular social, economic, and cultural characteristics. The type of screening instrument used and the resulting implementation procedures developed by a given school corporation will be dependent on the nature of the target population and the capacity of the school corporation to implement the screening procedures.

2. Instruments

A review of screening instruments has been compiled to aid the LEA in instrument selection. The instruments reviewed are listed in alphabetical order (Appendix A) and include the information:

Author	Who Administers
Copyright	Time to Administrate
Available from	Subtests
Purpose	Parent Questionnaire
How Administered	Standardization, Validity
Age Range	and Reliability



3. Instrument Analysis

In addition to the individual instrument reviews included in Appendix A, a Summary Chart of all the instruments has been prepared and is presented in Appendix B. The Summary Chart includes:

Copyright
Ages
Areas covered by instrument
Time per child
Cost per child
Number staff per instrument (approximate)
Category/level placement
Remarks

This information, reported on the Summary Chart, was obtained from research reports supplied by publishers, government documents, and reference books.

4. Screening Instrument Categories

Each instrument reviewed is considered in one of three categories/levels, depending upon the depth or extensiveness of information available through use of that instrument, cost to administer the instrument, and time per child.

Category I:

Instruments at this level are time efficient (regarding administration), usually less than 30 minutes per child; cost efficient (cost per child), usually less than \$5.00 per child, and may be administered by paraprofessionals.

In developing a screening program for the first time, an LEA would start with an instrument in this category.



Category II:

Instruments at this level offer more in-depth assessment of the child. The cost to administer the instrument is higher per child because of increased personnel. Usually administration of these assessment instruments requires professionals or highly trained para-professionals. The information obtained will confirm when a child needs full evaluation. The information may also be used to establish an educational baseline for each child. Implementation of screening, using instruments in Category II, requires more extensive planning and organizing than implementation of screening using those instruments in Category I.

Category III:

Instruments in Category III have been developed from remedial programs. The cost per child greatly increases (approximately \$10.00+ per child), and the number of staff needed to implement the screening program increases at the same rate. Information elicited is adequate for program planning and curricular development. A strong commitment to screening from the LEA personnel is needed when selecting a program from this category.

D. METHOD OF DELIVERY

Once a screening instrument has been selected, various means of implementing the screening program may be developed.

Appointment Approach:

Screening is administered by appointment only. Information is sent throughout the community regarding screening: time, place, and date. Parents are urged to call to make an appointment to have their children screened. The scheduling



Appointment Approach (continued)

of appointments will depend on the instrument used and the number of available staff. Through this structured process, extraneous variables (such as too many children for the screening unit to efficiently process) are minimized.

The appointment approach provides definitive information, such as:

1. How many children will be screened on a particular date;
2. How many days will be needed for screening; and
3. What will be the actual cost projection.

Roundup/Drop-in Approach:

Information regarding the screening is disseminated via TV, radio, newspapers, daycare centers, nursery schools, public/private schools, social organizations, PTO/PTA, etc. Facts regarding the time, date, site location, and purpose for the screening are presented.

The Drop-in approach offers less control of extraneous variables affecting the screening program.

1. Clients may be inconsistent in arrival, causing backlogs at some times and no activity at other times. A nursery room may be needed to accommodate waiting children.
2. Formal presentations to the parents will be more complex.
3. Accurately projected costs and staff needs will not be possible.

Large Local Educational Agencies may wish to use this approach, as absolute scheduling may not be possible.



Combination Referral/
Roundup Method:

This approach combines both the appointment and the roundup process for screening implementation. An appointment method is used early in the scheduled time table, i.e., first two days of a five-day schedule or the mornings are reserved for appointments. The rest of the allotted time is available for those who choose to drop in.

This combination approach provides flexibility in scheduling and administration.

1. Appointments will be available for those who prefer them.
2. Those children who are found by traditional "Child Find" methods may be screened.
3. Projected costs may be more accurately estimated.
4. If the appointment method is used first, the staff may have planned time to become familiar with individual tasks. When overload occurs, they will be better able to adjust to the situation.

Mobile Screening Unit:

This approach differs from other methods in that the screening team goes to the children. Visits are made to shopping centers, local schools, nursery schools, daycare centers, medical health centers, hospitals, recreation centers, etc. A converted bus, step-van or truck might be suitable for this type of delivery service. In terms of numbers of cost, large school corporations might best benefit from a mobile screening unit.



• Mobile...(continued)

The benefits of this approach include the following:

1. Flexibility will be maintained.
2. Outreach will be extended.
3. Screened populations will increase.
4. Parents will have more flexibility, and access to the screening process.
5. Community relations may be enhanced.



PART III - IMPLEMENTING THE SCREENING PROCESS

A. SCREENING CHECKLIST

The validity of a screening program is dependent, to a great degree, on the implementation process. The following checklist has been developed to aid screening coordinators in developing a smooth process. The list is not all inclusive and may be revised by local agencies to fit their individual needs.

SCREENING CHECKLIST

	DATE COMPLETED	PERSON RESPONSIBLE
1. SELECT COORDINATOR	_____	_____
2. SELECT COMMITTEE MEMBERS	_____	_____
3. SELECT SCREENING INSTRUMENT	_____	_____
4. SELECT SITES	_____	_____
5. SELECT PERSONNEL	_____	_____
6. SCHEDULE OF DATES	_____	_____
7. SCHEDULE OF TIMES	_____	_____
8. ALL APPROPRIATE FORMS DEVELOPED:		
A. REGISTRATION FORMS	_____	_____
B. RELEASE OF RECORDS	_____	_____
C. SOCIAL/MEDICAL	_____	_____
9. TRAIN SCREENING PERSONNEL	_____	_____
10. NOTIFICATION OF PROGRAM:		
A. SUPERINTENDENT	_____	_____
B. SCHOOL BOARD	_____	_____
C. PARENTS	_____	_____
D. PUBLIC/PRIVATE AGENCIES	_____	_____
11. COMMUNITY AWARENESS PROGRAM:		
MEDIA RELEASES		
TV, RADIO	_____	_____
NEWSPAPERS	_____	_____
SCHOOL PUBLICATIONS	_____	_____
REPORT CARDS	_____	_____
FLIERS	_____	_____
OTHER	_____	_____
12. FINALIZE DATES & PERSONNEL:		
A. DATES	_____	_____
B. SITES	_____	_____
C. SCREENING PERSONNEL	_____	_____
D. PARENT INTERVIEWERS	_____	_____
E. NURSERY ATTENDANTS	_____	_____
F. RECEPTIONISTS	_____	_____
G. VISION/HEARING PERSONNEL	_____	_____
H. OTHER	_____	_____
13. FINAL MATERIAL CHECK	_____	_____
14. FINAL SITE CHECK	_____	_____
15. FOLLOW-UP COMMUNICATIONS:		
A. POSITIVE RESULTS	_____	_____
B. NEGATIVE RESULTS	_____	_____
C. REFERRALS	_____	_____
D. RESCREENING	_____	_____



B. ON-SITE IMPLEMENTATION PROCESS

The following screening process may be adapted to any instrument selected:

Step 1: Entry

The child and parent/guardian enter the screening site, are welcomed by a staff person, and are directed to the reception area. A place for coats and personal belongings should be provided.

Step 2: Reception

The necessary forms are completed: kindergarten registration, social/medical information, and permission slips. The screening procedure should also be explained to the family at this time.

Resources available at the reception desk to aid parents in completing forms include: telephone books, community reference books, and activity handout sheets (if available).

Sibling area may be provided, where the children can occupy their time so as not to distract those children being screened. A volunteer parent could easily staff this area.

Step 3: Screening

The parent and child move through the screening process together. This enables the parent/guardian to become part of the process. The adult can see what is being requested of the child as well as how the child is performing.

The evaluator needs to concentrate his/her attention on the child. This indirectly tells the parent not to answer for him. If the parent ignores this indirect method and tries to help the child, usually a simple hand gesture



Step 3...(continued)

(to stop) is sufficient. If the screening site has more than one test station, waiting area may need to be provided. This area could be in close proximity to the next station. The parent and child can observe what is to be expected and if there is any anxiety, it may lessen.

When vision/hearing screening is offered, a quiet area needs to be provided. A separate room is preferred.

Step 4: Check-out

The family leaves the screening area and proceeds to the check-out desk. Here the child's screening folder is checked by a staff member and immediate feedback given. Screening results are explained, i.e., description of the child's performance at various tasks. Total evaluation is not presented to the parents at this time.

The child may be presented with some type of treat, although permission from the parent/guardian needs to be obtained first. Examples of different types of treats: Kool-aid, balloons or favors provided by a local group or company.

Step 5: Evaluation

Time needs to be allotted, at the end of the day, when all personnel meet and evaluate test results and procedures.

Step 6: Notification

All families involved in the screening process should receive written reports within two weeks of the final screening date.

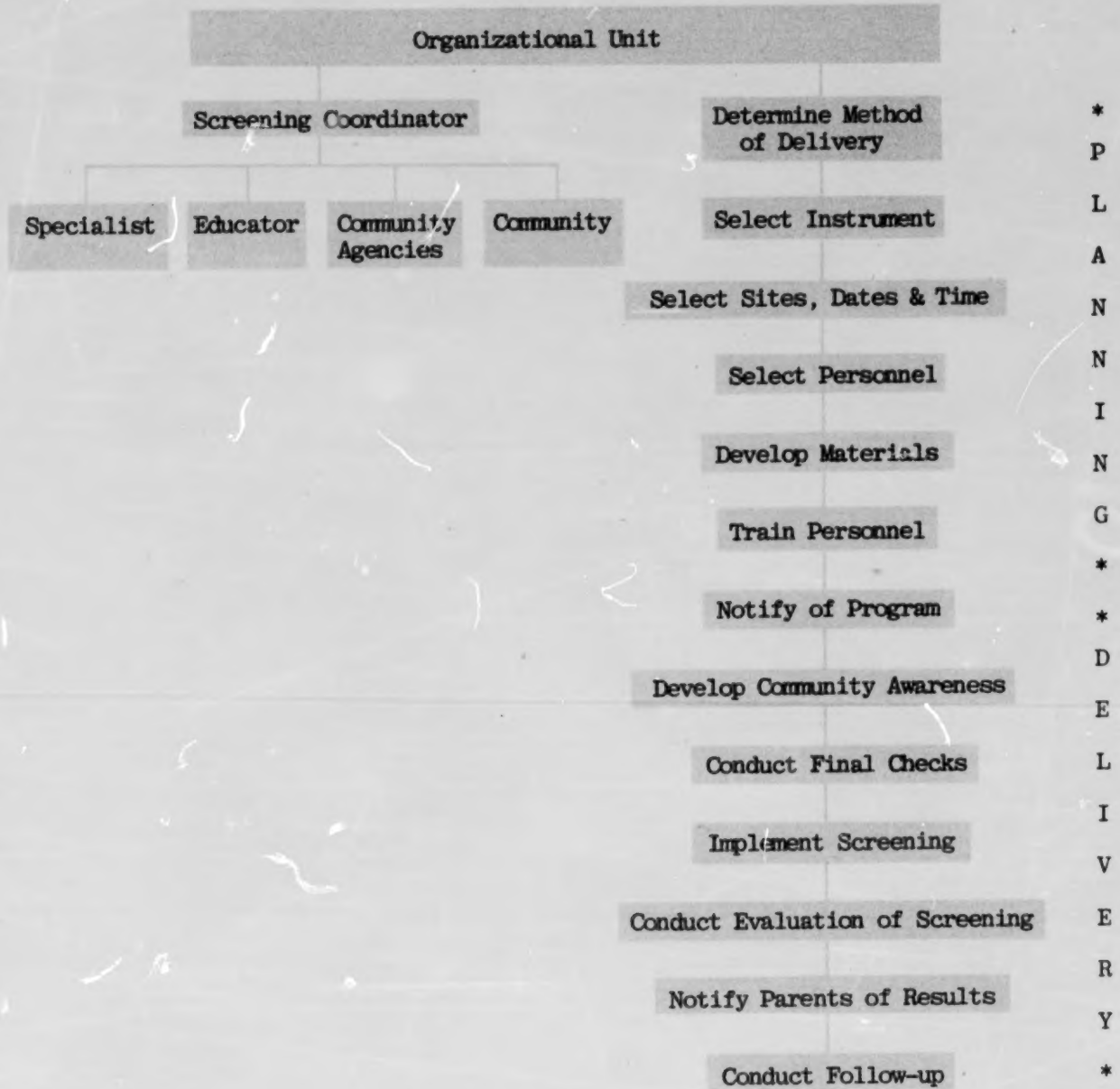
Step 7: Follow-up

For those children identified as high risk by the screening process, procedures outlined in P.L. 94-142 and Rule S-1 are to be followed as are rules regarding confidentiality of information.



RECORD KEEPING

SCREENING MODEL



CHILD

Author:	E. Medvedeff, Ph.D. B. Dearth, Ph.D.
Copyright:	1976
Available from:	Westinghouse Learning Corp. P.O. Box 30 Iowa City, Iowa 52240
Purpose:	To provide for reliable early identification, diagnosis, and treatment of children with learning disabilities. It provides a complete program.
How Administered:	Individual/Group
Age Range:	K through 6th grade
Who Administrates:	Professionals, Teachers or Paraprofessionals
Time to Administrate:	1 - 1½ hour
Subtests:	Visual Motor Visual Speech/Hearing Physical Behavior Psycho-Motor Psychological
Parent Questionnaire:	None
Standardization:	Normed on 6 through 7-year olds
Reliability & Validity:	Not Available
Category:	III



CLASSROOM SCREENING

Author:	Circle Preschool-First Chance Project
Copyright:	1977
Available from:	Circle Preschool 9 Lake Ave. Piedmont, CA 94611
Purpose:	The primary purpose of the screening instrument is to spot that child with a serious developmental delay. Secondary purpose of this instrument is to assess a child's knowledge and ability.
How Administered:	Group. Within one month of beginning school.
Age Range:	2 years, 6 months through 5 years
Who Administers:	Teacher/Teacher Aide
Time to Administrate:	Untimed
Subtests:	Gross/Fine Motor Cognitive Language Social/School adaptive Self-Help
Parent Questionnaire:	None
Standardization:	Not reported
Reliability & Validity:	Not reported
Category:	II



COMPREHENSIVE IDENTIFICATION PROCESS
(CIP)

Author:	R. Reid Zehrbach, Ph.D.
Copyright:	1975
Available from:	Scholastic Testing Service, Inc. 480 Meyer Rd. Bensenville, IL 60106
Purpose:	Provides a systematic outreach screening method for children who may have special needs.
How Administered:	Individual
Age Range:	2 years, 6 months through 5 years, 6 months
Who Administers:	Teacher/Paraprofessionals
Time to Administrate:	30-35 minutes
Subtests:	Cognitive Verbal Social affective Fine/Gross Motor Medical History Speech/Expressive Language Hearing/Vision
Parent Questionnaire:	Comprehensive
Standardization:	Items were standardized at national level but reorganized to identify children progressing at developmental rate lower than 80-90% of average population.
Reliability & Validity:	Reliability not reported. Validity: 90% of children indicated as needing help actually needed it when diagnosed by full evaluation.
Category:	I



COOPERATIVE PRESCHOOL INVENTORY

Author:	Dr. Bettye M. Caldwell
Copyright:	Revised Edition - 1970 Spanish - 1974
Available from:	Addison-Wesley Testing Service South Street Reading, Massachusetts 01867
Purpose:	It was developed to give a measure of achievement in areas regarded as necessary for success in school.
How Administered:	Individual
Age Range:	3-6 years
Who Administrates:	Professional/Paraprofessional
Time to Administrate:	25-35 minutes
Subtests:	Personal-Social Responsiveness Associative Vocabulary Concept Activation-Numerical Concept Activation Sensory
Parent Questionnaire:	None
Standardization:	Standardized on 1700 children based in 11 Head Start programs.
Reliability & Validity:	Concurrent validity ranged from .39 to .65 Reliability ranged from .86 to .92
Category:	I



DENVER DEVELOPMENTAL SCREENING TEST

Author:	W. Frankenburg, M.D., A. W. Fandal, J. Dobbs, Ph.D.
Copyright:	1967, 1970, 1975
Available from:	LADUCA East 51st Ave. and Lincoln St. Denver, Colorado 80216 (303) 629-6379
Purpose:	It was designed and standardized to meet the need of having a simple, useful tool to aid in the early discovery of children with developmental delays.
How Administered:	Individual observation/or some questions can be answered by parents.
Age Range:	Birth - six years
Who Administrates:	Professional/Paraprofessional
Time to Administrate:	10-20 minutes
Subtests:	Personal-Social Language Fine Motor adaptive Gross Motor
Parent Questionnaire:	Some questions could be answered by parent.
Standardization:	Standardized on children (543 males, 493 females) between one month and 6 years of age. Sample reflects the ethnic, occupational, and economic characteristics of Denver.
Reliability & Validity:	Validity and reliability are reported high.
Category:	I



DEVELOPMENTAL INDICATORS FOR THE ASSESSMENT OF LEARNING

Author:	Carol Mardell, Ph.D. and Dorothea Goldenberg, M.A.
Copyright:	1972, 1975
Available from:	Childcraft Education Corp. 20 Kilmer Rd. Edison, NJ 08817
Purpose:	Its purpose is to identify those children who need a diagnostic evaluation.
How Administered:	Individual
Age Range:	2 years, 6 months through 5 years, 6 months
Who Administers:	Team of professionals, paraprofessionals and volunteers
Time to Administrate:	25-30 minutes
Subtests:	Gross/Fine Motor Communications Concepts
Parent Questionnaire:	None
Standardization:	This instrument was standardized on a sample of 4,356 children, cross cultural.
Reliability & Validity:	Reliability and validity have been established. Further information can be obtained from an article on "Journal of Learning Disabilities". (March, 1975)
Category:	I

DEVELOPMENTAL PROFILE

Author:	Gerald Alpern, Ph.D. and Thomas Boll, Ph.D.
Copyright:	1972
Available from:	Psychological Development Publications P.O. Box 3198 Aspen, CO 81611
Purpose:	The purpose of this instrument is to provide reliable screening in 5 key areas.
How Administered:	Individual
Age Range:	Birth through 12 years
Who Administers:	Diagnostician, Teacher or Parent
Time to Administrate:	30-40 minutes
Subtests:	Physical Academic Self-help Communication Social
Parent Questionnaire:	Parent can be involved in completing the profile.
Standardization:	Standardization was completed on 3,008 children ranging from 6 months to 12 years.
Reliability & Validity:	Validity was reported .86 (construct validity). Reliability was reported high.
Category:	II



EARLY CHILDHOOD ASSESSMENT: A CRITERION REFERENCED SCREENING DEVICE

Author:	Developed by Robert Wendt
Copyright:	Copyright not given Developed 1972, 1973, 1974
Available from:	Robert Schramm, Project Director 908 W. Main St. Wausau, WI 53983
Purpose:	The instrument has been designed to help locate the child along a developmental curriculum sequence.
How Administered:	Individual
Age Range:	3 years through 5 years
Who Administers:	Teacher, Volunteers, or Paraprofessionals
Time to Administrate:	40-50 minutes
Subtests:	Auditory Perception Motor Coordination Visual Perception (Gross & Fine) Language
Parent Questionnaire:	Questions are asked by Psychologist
Standardization:	Criterion-Referenced
Reliability & Validity:	Criterion-Referenced
Category:	II



EARLY PREVENTION OF SCHOOL FAILURE

Author:	Peotone School District sponsored by: Illinois Office of Ed., Title IV ESEA, Part C and U.S. Office of Education, National Diffusion Network
Copyright:	Its inception was 1971
Available from:	Peotone 207-U Administrative School District Mrs. Lucille Werner, Director Early Prevention of School Failure 114 N. Second St. Peotone, IL 60468
Purpose:	To demonstrate that failure in school can be prevented through early identification and remediation of developmental deficiencies in children entering school.
How Administered:	Individual
Age Range:	3 - 6 years
Who Administrates:	Professionals, teachers or paraprofessionals
Time to Administrate:	20 children/1½ hours
Subtests:	Visual Language Auditory Fine Motor Gross Motor
Parent Questionnaire:	Yes
Standardization:	This instrument/program is used at 400 different sites in 40 states and several foreign countries.
Reliability & Validity:	None reported
Category:	III



ELIOT-PEARSON SCREENING INSTRUMENT

Author:	Samuel J. Meisels, Ed. D. M. Stone Wiske, M.A.
Copyright:	1976
Available from:	Eliot-Pearson Department of Child Study Tufts University 105 College Ave. Medford, Mass. 02155
Purpose:	The E.P.S.I. is designed to provide a brief and easily administered survey of children's development in a number of significant areas.
How Administered:	Individual
Age Range:	4 - 6 years
Who Administers:	Teacher/Paraprofessionals
Time to Administrate:	15 minutes
Subtests:	Perceptual Cognitive Language Parent Questionnaire Motor Medical Hearing/Vision
Parent Questionnaire:	Comprehensive
Standardization:	Normed on 2,500 children. Most were residents of a high density urban residential and commercial city.
Reliability & Validity:	Inter-tester reliability and test-retest reliability measures are consistently high. Validity measures are still incomplete
Category:	I



GENERAL INVENTORY FOR KINDERGARTEN

Author:	N. Nale, T. L. Harris, F. Sucher, W. H. Lane and T. D. Yawkey
Copyright:	1975
Available from:	The Economy Co. 5455 W. 84th St. Indianapolis, IN
Purpose:	To provide information for planning individual instructional needs.
How Administered:	Individual
Age Range:	Kindergarten
Who Administrates:	Teachers/paraprofessionals or parents
Time to Administrate:	30 minutes
Subtests:	Sect. I General Concepts Sect. II Social Self-concept & Independence Memory Attitude & Interest in Sch. Motor Social Relationships Problem Solving
Parent Questionnaire:	Parent could be involved in interview process.
Standardization:	Not reported
Reliability & Validity:	Not reported
Category:	I



THE MAGIC KINGDON (PRESCHOOL SCREENING PROGRAM)

Author:	Southeast Mental Health: Retardation Center
Copyright:	1975
Available from:	Southeast Mental Health and Retardation 700 1st Ave. So. Fargo, ND 58102
Purpose:	To provide local communities, school districts, and parents and effective efficient, low cost, and comprehensive screening of young children.
How Administered:	Individual
Age Range:	3-6 years
Who Administrates:	Professionals, parents, paraprofessionals
Time to Administrate:	20 children per hour
Subtests:	Hearing/Vision Walker Readiness Motor Child Level History Auditory Develop. Prototypic Assoc. Language Fargo Pression Screening Test Self-concept
Parent Questionnaire	Parents are integral part of screening process
Standardization:	Not reported
Reliability & Validity:	Not reported
Category:	II & III



McCARTHY SCALES OF CHILDREN'S ABILITIES

Author:	Dorothea McCarthy
Copyright:	1970, 1972
Available from:	The Psychological Corp. 7555 Caldwell Ave. Chicago, IL 60648
Purpose:	The McCarthy was designed to give an in-depth evaluation of children suspected of "Learning Disabilities".
How Administered:	Individual
Age Range:	2 years, 6 months through 8 years, 6 months
Who Administrates:	Professionally trained personnel
Time to Administrate:	1 - 1½ hours
Subtests:	Variety of cognitive and motor behaviors are provided for six scales: 1. Verbal 2. Perceptual-Performance 3. Quantitative 4. General Cognitive 5. Memory 6. Motor
Parent Questionnaire:	None
Standardization:	The norms are representative of the U.S. population of children ages 2.5 - 8.5. Variables used were: age, sex, race, geographic region and father's occupation.
Reliability & Validity:	Validity correlations with Stanford-Binet Wechsler Preschool and Primary Scale of Intelligence ranged from .62 - .81. Reliability: split half and test-retest ranged from .79 - .93.
Category:	II



McCARTHY SCREENING TEST

Author:	Dorothea McCarthy
Copyright:	1970, 1972, 1978
Available from:	The Psychological Corp. 7555 Caldwell Ave. Chicago, IL 60648
Purpose:	To predict a child's ability to cope with schoolwork in the early grades.
How Administered:	Individual
Age Range:	4 through 6 years, 6 months
Who Administrates:	Teacher or trained paraprofessional
Time to Administrate:	15-20 minutes
Subtests:	Verbal Memory Right-Left Orientation Leg Coordination Draw-a-Design Numerical Memory Conceptual Grouping
Parent Questionnaire:	None
Standardization:	Not reported
Reliability & Validity:	Not reported
Category:	I



MEETING STREET SCHOOL SCREENING TEST

Author:	Peter K. Hainsworth & Marian L. Siqueland
Copyright:	1969
Available from:	Meeting Street School 667 Waterman Ave. East Providence, R.I. 02914
Purpose:	To aid in identification of those Kindergarten and 1st grade children who do not possess adequate skills for traditional school curriculum.
How Administered:	Individually
Age Range:	5 through 7 years, 6 months
Who Administrates:	Professional, teacher or trained paraprofessional
Time to Administrate:	15-20 minutes
Subtests:	Language Visual Perception/Motor Motor Patterning
Parent Questionnaire:	None
Standardization:	100 children representative of U.S. population
Reliability & Validity:	Validity: correlated with ITPA = .77 and with Frostig = .57 Reliability: Test-retest for two- to four-week period .85, inter-rater reliability .95
Category:	II - can be used as a screening instrument only, but it would aid in diagnostic evaluation.



MINNESOTA PRESCHOOL SCALE

Author:	Florence L. Goodenough and others
Copyright:	1938-1940
Available from:	American Guidance Service, Inc. Publishers' Building Circle Pines, Minnesota 55014
Purpose:	It is designed to test verbal and non-verbal intelligence
How Administered:	Individual
Age Range:	18 months through 6 years
Who Administers:	Trained professionals
Time to Administrate:	30 minutes
Subtests:	Response to Pictures Vocabulary Comprehension Opposites Absurdities Speech
Parent Questionnaire:	None
Standardization:	Standardized on 900 children 100 at each half-age level
Reliability & Validity:	Reliability and validity measurement are available from test authors
Category:	II



PRESCHOOL ATTAINMENT RECORD

Author:	Edgar A. Doll, Ph.D.
Copyright:	1966
Available from:	American Guidance Service, Inc. Publisher's Building Circle Pines, Minnesota 55014
Purpose:	The PAR combines the assessment of physical, social and intellectual functions in a global appraisal of young children.
How Administered:	Individual
Age Range:	Birth through 7 years
Who Administrates:	Trained professionals
Time to Administrate:	10-20 minutes
Subtests:	Ambulation Manipulation Responsibility Information Rapport Communication Ideation Creativity
Parent Questionnaire:	None
Standardization:	Not reported
Reliability & Validity:	Not reported
Category:	II



PRESCHOOL SCREENING SYSTEM

Author:	Peter Hainsworth and Marian Hainsworth
Copyright:	1974
Available from:	Preschool Screening System Box 1635 Pawtucket, R.I. 02862
Purpose:	This instrument is to be used for a quick survey of the learning skills of large numbers of entering Kindergarten or nursery school children, so that curriculum may be better oriented toward their needs.
How Administered:	Individual
Age Range:	4 years, 4 months through 5 years, 4 months
Who Administrates:	Professionals, teachers, paraprofessionals
Time to Administrate:	15-20 minutes
Subtests:	Language Visual Perceptual Body Awareness & Control Verbal Reasoning Draw-a-Person Parent Interview Form
Parent Questionnaire:	Fifteen to twenty-five minutes in length includes items regarding behavioral characteristics of child's skills, and "behavior at home" as well as short medical and developmental history.
Standardization:	Normative data from over 600 children.
Reliability & Validity:	Reliability and validity was adequate. New data is in the process of being compiled.
Category:	I

PRESCHOOL SCREENING SYSTEM - SUPPLEMENTAL EDITION

Author:	Peter Hainsworth and Marian Hainsworth	
Copyright:	1977	
Available from:	Preschool Screening System Box 1635 Pawtucket, R.I. 02862	
Purpose:	To supplement 1974 edition of the P.S.S.	
How Administered:	Individual	
Age Range:	2 years, 6 months through 4 years, 3 months	
Who Administrates:	Teacher/Paraprofessional	
Time to Administrate:	15-20 minutes	
Subtests:	Language Visual Perceptual Body Awareness	Verbal Reasoning Draw-a-Person Parent Interview Form
Parent Questionnaire:	Fifteen to twenty-five minutes in length includes items regarding behavioral characteristics of child's skills, and "behavior at home" as well as a short medical and developmental history.	
Standardization:	1974 edition reported normative data from over 600 children.	
Reliability & Validity:	Reliability and validity was adequatq. New data for both instruments is in process of being compiled.	
Category:	I	



PROJECT MEMPHIS

Author:	A. D. Quick, Ed.D. A. A. Campbell T. L. Little, Ed.D.
Copyright:	1974
Available from:	Fearon-Pitman Publishers, Inc. 6 Davis Dr. Belmont, CA 94002
Purpose:	The three instruments which comprise this package are a system of individual program planning. Three steps: 1. Developmental evaluation 2. Individual program planning 3. Education evaluation
How Administered:	Individual
Age Range:	Birth through 5 years
Who Administrates:	Teacher - Paraprofessional
Time to Administrate:	Untimed: est. 40-45 minutes
Subtests:	Language Development Motor Development Social Development
Parent Questionnaire:	None
Standardization:	Not reported
Reliability & Validity:	Not reported
Category:	III



TOTAL INDIVIDUAL PROGRESS

Author:	Delaware Community School Corp. Funded by ESEA Title III
Copyright:	1977
Available from:	Total Individual Progress Carl T. Swift, Superintendent Delaware Community School Corp. R. R. 3 Muncie, IN 47302
Purpose:	T.I.P. is a combination of research, demonstration, and remediation aimed at defining, understanding, and treating the total child.
How Administered:	Individual
Age Range:	K through 12th grade
Who Administrates:	P.P.S. team
Time to Administrate:	Est. 2-2½ hours
Subtests:	The screening instrument has 56 behavioral components.
Parent Questionnaire:	Parent Interview Form
Standardization:	Criterion Referenced
Reliability & Validity:	Not reported
Category:	III



SANTA CLARA INVENTORY OF DEVELOPMENTAL TASKS (I.D.T.)

Author:	Senior Editor: William L. Gainer, Ed.D.
Copyright:	1974
Available from:	Burke's Audio-Visual Center 2207 S. Michigan St. P.O. Box 2798 South Bend, IN 46860
Purpose:	'Failure-prevention program' in the assessment of young children and as a developmental guide for ongoing instruction
How Administered:	Individual/Group
Age Range:	Preschool through 7 years
Who Administrates:	Professionals/Teachers/Teacher's Aide
Time to Administrate:	Approximately 1 hour
Subtests:	Motor Coordination Auditory Perception Visual Motor Auditory Memory Visual Perception Language Development Visual Memory Conceptual Development
Parent Questionnaire:	None
Standardization:	Not reported
Reliability & Validity:	Not reported
Category:	III



YELLOW BRICK ROAD

Author:	Christine Kallstrom, Ph.D.
Copyright:	1975
Available from:	Learning Concepts 2501 N. Lamar Austin, TX 78705
Purpose:	To provide insight into the strengths and weaknesses in motor, visual, auditory, language functioning of individual preschools. It also has follow-up Developmental Activities.
How Administered:	Individuals
Age Range:	5 and 6 years
Who Administrates:	Parents/Professionals - recommend 2/station
Time to Administrate:	24 children simultaneously in approximately 2 hours
Subtests:	Motor Battery Language Battery Auditory Battery Visual Battery
Parent Questionnaire:	
Standardization:	350 children age 4-9 through 6-9 from 10 public schools in Grand Prairie, Texas. Other agencies throughout the country have used it.
Reliability & Validity:	Studies show $r=.77$ with M.R.T., $.80$ with I.T.P.A., $.70$ with teachers rating
Category:	II



APPENDIX B
SUMMARY CHARTS

SUMMARY CHART



Instrument	Copyright	Ages	Areas Covered by Instrument											Ref.		Time Per Child (min.)	Cost Per Child*	Number Staff Per Instrument** (approximate)	Cat. I	Cat. II	Cat. III	Remarks
			Language	Perception	Fine M.	Gross M.	Social	Emotional	School Readiness	Reasoning	Self Help	Parent Form	Stand.	Norm	Criterion							
ABC Inventory	1965	3.6 - 6.7	*	*					*	*			*	*		10	1.30/2.00	1 Professional/Teacher 2 Paraprofessionals/Volunteers	*			
Child	1976	k-12	*	*	*	*	*		*				*	*	*	2-2½	15.00/20.00	4 Professionals/Teachers 4 Paraprofessionals			*	Complete packaged program
Classroom Screening (First Change Project)	1977	2.5 - 5.0	*		*	*	*		*		*					untimed	N/A	N/A	*			Group assessment instrument
Comprehensive Identification Process	1975	2.5 - 5.5	*		*	*			*	*			*	*		30-35	4.00/4.50	2 Professionals/Teachers 2 Paraprofessionals/Volunteers	*			Hearing/Vision Medical Parent Forms
Cooperative Preschool Inventory	1970	3-6	*				*		*				*	*		25-35	3.25/4.00	1 Professional/Teacher 3 Paraprofessionals/Volunteers	*			Standardized on Head Start Children. Spanish Edition 1974

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* Cost per child excludes the cost of screening materials and costs for vision and hearing personnel/materials.

** Does not include personnel for vision and hearing

SUMMARY CHART

Instrument	Copyright	Ages	Areas Covered by Instrument												Ref.	Time Per Child (min.)	Cost Per Child*	Number Staff Per Instrument** (approximate)	Cat. I	Cat. II	Cat. III	Remarks
			Language	Perception	Fine M.	Gross M.	Social	Emotional	School Readiness	Reasoning	Self Help	Parent Form	Stand.	Norm.	Criterion							
Denver Developmental Screening Test	1967 1970 1975	0-6	★		★	★							★	★		10-20	3.25/3.75	1 Professional 3 Paraprofessionals/Volunteers	★			Allows for charting of progress, periodic testing can take place on the same form. Spanish Ed. Prescreening forms.
Developmental Indicators for the Assessment of Learning (DIAL)	1972 1975	2.5-5.5	★		★	★			★				★	★		25-30	3.50/4.00	2 Professionals 3 Paraprofessionals	★			Could be a CAT. II instrument because of initial cost and large screening staff
Developmental Profile	1972	0-12	★		★	★			★		★	★	★	★		30-40	4.00/4.50	1 Professional/Teacher 3 Paraprofessionals/Volunteers		★		Standardization Indiana population
Early Childhood Assessment: A criterion referenced device	1972 1973 1974	3-5	★	★	★	★						★			★	40-50	10.50/11.50	4 Professionals 4 Paraprofessionals			★	Sequential curriculum-based program
Early Prevention of School Failure	inception was 1971	3.0-6.0	★	★	★	★						★			★	20 children per 1½ hour	9.50/10.50	4 Professionals/Teachers 4 Paraprofessionals/Volunteers			★	Recommended to be used with regular K-school curriculum

* Cost per child excludes the cost of screening materials and costs for vision and hearing personnel/materials.

** Does not include personnel for vision and hearing

SUMMARY CHART

Instrument	Copyright	Ages	Areas Covered by Instrument													Ref.	Time Per Child (min.)	Cost Per Child*	Number Staff Per Instrument** (approximate)	Cat. I	Cat. II	Cat. III	Remarks
			Language	Perception	Fine M.	Gross M.	Social	Emotional	School Readiness	Reasoning	Self Help	Parent Form	Stand.	Norm	Criterion								
Eliot-Pearson Screening Inventory	1976	4.0 - 6.0	★	★	★	★			★			★	★	★		15	1.75/2.25	2 Professionals 2 Paraprofessionals	★			Medical Hearing/Vision Comprehensive Parent Questionnaire	
General Inventory for Kindergarten	1975	K		★	★	★	★			★			★	★		25-30	3.25/4.00	1 Professional 3 Paraprofessionals	★			Would need to supplement this instrument with another one that reaches younger children	
Magic Kingdom: Preschool Screening Program	1975	3-6	★		★	★			★			★				20 child-per 1 hr.	11.00/12.00	4 Professionals/Teachers 4 Paraprofessionals		★		Hearing/Vision Self-Concept Very comprehensive	
McCarthy Scales of Children's Abilities	1970 1972	2.5 - 8.5	★	★	★	★			★							1-1½ hr.	10.50/11.50	5 Professionals 2 Paraprofessionals		★		Memory Needs professional administration	
McCarthy Screening Test	1970 1972 1978	4.0 - 6.5	★	★	★	★			★							15-20	2.75/3.25	2 Professionals 2 Paraprofessionals	★			Memory Shorten form of complete instrument	

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* Cost per child excludes the cost of screening materials and costs for vision and hearing personnel/materials.

** Does not include personnel for vision and hearing

SUMMARY CHART

Instrument	Copyright	Ages	Areas Covered by Instrument													Ref.		Time Per Child (min.)	Cost Per Child*	Number Staff Per Instrument** (approximate)	Cat. I	Cat. II	Cat. III	
			Language	Perception	Fine M.	Gross M.	Social	Emotional	School Readiness	Reasoning	Self Help	Parent Form	Stand.	Norm	Criterion									
Meeting Street School Screening Test	1969	5-7½	★	★	★								★	★			15-20	2.75/3.50	3 Professionals/ Teachers 2 Paraprofessionals		★		Can be used as screening instrument only; it would also aid in diagnostic evaluation	
Minnesota Preschool Scale	1938 1940	1.5 - 6.0	★	★	★					★			★	★			30-40	5.00/6.00	4 Professionals 2 Paraprofessionals		★		Absurdities Opposites Speech Clinical Record Professionally administrated	
Preschool Attainment Record: PAR	1966	0-7.0	★			★	★	★		★							10-20	3.75/4.50	4 Professionals 2 Paraprofessionals		★		Global appraisal of young children	
Preschool Screening System	1974	4.4 - 5.4	★	★	★	★				★	★	★	★	★			15-20	2.75/3.50	3 Professionals/ Teachers 2 Paraprofessionals	★			Use with Supplement Edition (1977)	
Preschool Screening System - Supplement Edition	1977	2.6 - 4.3	★	★	★	★				★	★	★	★	★			15-20	2.75/3.50	3 Professionals/ Teachers 2 Paraprofessionals	★			Use with original edition (1974)	

* Cost per child excludes the cost of screening materials and costs for vision and hearing personnel/materials.

** Does not include personnel for vision and hearing

SUMMARY CHART

Instrument	Copyright	Ages	Areas Covered by Instrument													Ref.		Time Per Child (min.)	Cost Per Child*	Number Staff Per Instrument** (approximate)	Cat. I	Cat. II	Cat. III	Remarks
			Language	Perception	Fine M.	Gross M.	Social	Emotional	School Readiness	Reasoning	Self Help	Parent Form	Stand.	Norm	Criterion									
Project Memphis	1974	0-5	★		★	★	★								★	Est. 40-45	9.50/10.25	4 Professionals 4 Paraprofessionals				★	Evaluation Program Educational Evaluation	
Total Individual Progress	1977	K-12										★			★	Est. 2-24 hr.	N/A	N/A				★	56 components are examined. Was awarded "Educational Pacesitter Award"	
Yellow Brick Road	1975	5.0 - 6.0	★	★	★	★	★							★	★	24 children per 2 hrs.	5.50/6.25	2 Professionals/Teachers 4 Paraprofessionals		★			Follow-up developmental activities are available.	
Santa Clara	1975	Pre-school - 7.0	★	★	★	★	★		★						★	1-1½ hrs.	10.00/11.00	5 Professionals 3 Paraprofessionals				★	Remedial Program	

FORMULAS IN COMPUTING

COST PER CHILD

Formula for calculating
estimated population/week

$$\text{Estimated population/wk} = \frac{\text{Tot. min. screening/wk} \times \text{Tot. \# of screeners}}{\text{Instrument time/child}}$$

Formula for calculating
cost/child

$$\text{Cost/child} = \frac{\text{Salary/wk} \times \text{\# of Staff}}{\text{Est. screened pop/wk}}$$

Definitions:

Tot. min/wk = Total minutes of actual screening time per week,
(6 hrs/day; 5 days/week)

Est. pop/wk = Estimated population that could be screened in one work
week with given instrument.

\# of screeners = Number of adults needed to conduct the screening
process "hands on service", excluding vision/hearing.

Time/child = Recommended screening time per child, from publishers
information.

Total Staff Cost = Total staff cost can be calculated by using the
following schedule:

Professional/teacher = \$350/wk x No. of professionals
Paraprofessional = \$125/wk x No. of paraprofessionals



APPENDIX C

PARTICIPATING ORGANIZATIONS AND PERSONNEL

INDIANA DEPARTMENT OF PUBLIC INSTRUCTION

Harold H. Negley, Superintendent
Gilbert Bliton, Director of Special Education
Sara Cochran, Coordinator, Preschool Programs

INDIANAPOLIS PUBLIC SCHOOLS

Board of School Commissioners:
Lillian Davis, President
Mary E. Busch
Patricia Welch
Robert D. DeFrantz
Walter Knorr
Donald Larson
James R. Riggs

Karl R. Kalp, Superintendent
Patricia Alexander, Ass't. Superintendent, Special Services
David Greenburg, Supervisor of Special Education

ELEMENTARY PRINCIPALS

Kenneth Hughes
School #18

Martha Bradley
School #38

Charles Robinson
School #53

Beatrice Bowles
School #63

William Wilson
School #65

Phyllis Imel
School #75

Ruth Harris
School #106



PARTICIPATING . . . (continued)

Adams-Wells Joint Services
Lowell Schultz
Director of Special Education

Clay Community Schools
Michael Livovich, Jr.
Director of Special Education

County School Corporation
of Brown County
Cynthia Salmon
Special Education Coordinator

Cowan High School
Larry Nicholson
Principal

Evansville-Vanderburgh School Coop.
Lewis Browning
Director of Special Education

Greater Lafayette Area Special
Services
Paul Lane
Director of Special Education

Huntington-Whitley Area Programs
for Exceptional Children
William Kruzan
Director of Special Education

Indiana Society for the Prevention
of Blindness, Inc.
Sandra A. Klapper
Ass't. Program Director

JESSE - A School Program
A. H. Dulle
Director of Special Education

M.S.D. of Pike Township
Vernon Black
Director of Special Education

M.S.D. of Warren Township
Niles Daggy
Director of Special Education

Madison Area Special
Services Unit
William Littlejohn
Director of Special Education

Madison Consolidated Schools
John Graham
Director of Special Education

Madison-Grant United School Coop.
Lora Nell Spence
Director of Special Education

Marshall-Starke Development
Centers, Inc.
Roger Senkbell
Executive Director

Michigan City Area Schools
Dennis Martin
Director of Special Education

Monroe County Community
School Corporation
Jerry L. Keener
Director of Special Education

The M.S.D. of Wabash County
Edward Kasamis
Superintendent



PARTICIPATING . . . (continued)

North Central Indiana Special
Education Coop.
James Dalker
Director of Special Education

Posey County Special Education
Services
Robert Domizio
Supervisor of Special Education

Northeast Indiana Special
Education Coop.
William McKinney
Director

School City of Hammond
Jeanne Tibbles
Coordinator
Special Education Programs

Northwest Indiana Special
Education Coop.
Richard Surber
Director of Special Education

School City of Mishawaka
John Shotts
Director of Pupil Personnel

Porter County Special Education Coop.
Michael Haley
Director of Special Education

Special Services . . . Johnson
County Schools
Shirley Amond
Director of Special Education

Wabash-Miami Area Program
for Exceptional Children
Noel Reed
Director of Special Education



APPENDIX D
PILOT SITE REVIEWS

SUMMARY OF PILOT SITES SCREENING PROGRAMS

Selected Pilot Sites

Three LEA's were selected to conduct the Screening Program:

1. Indianapolis Public Schools
Indianapolis, Indiana
Special Education Supervisor: Mr. David Greenburg
Screening Coordinator: Mr. Joseph Leuer
2. Covered Bridges Special Education District
Terre Haute, Indiana
Director of Special Education: Mr. David Weber
Child Find Coordinator: Ms. Diane Wittenauer
3. Porter County Special Education Coop.
Valparaiso, Indiana
Director of Special Education: Mr. Michael Haley
Screening Coordinator: Mr. Larry Miller

Summary - I.P.S. Screening Program

The Indianapolis Preschool Screening Program was conducted between May 21 and May 31, 1979. Seven schools located throughout the city were selected to service other nearby schools.

The instruments used for the program, Inventory for Kindergarten and Denver Prescreening Developmental Questionnaire, were selected because of their existence in service areas within I.P.S.; namely, the Kindergarten Program and Home Bound Program.

Four paraprofessionals (non-certified substitute teachers) were trained, by the program coordinator, to administer the instruments. The format for "inservice" included a complete examination of the instruments, developing a sensitivity to the children and ways of responding to the



children, cues about what to observe and how to ask questions. After the staff became familiar with the instruments, the testing stations were set up and the examiners role-played the screening process.

A drop-in approach was utilized in I.P.S. Parents accompanied the child being screened through the various stations. They could come at their convenience and were able to move through the process with minimal amount of waiting time. Verbal feedback was provided to the parents upon departing; and, within a short period of time, follow-up letters were mailed to all participants.

The total number of children screened was as follows:

<u>Age</u>	<u>Number</u>	<u>Need further testing</u>
Kindergarten	130	16
Four-year olds	63	7
Three-year olds	22	2

Summary - Covered Bridge Special Education District Screening Program

Covered Bridges Screening Program was conducted during the last week of May and first week of June, 1979. The instrument used was the Comprehensive Identification Process (CIP), published by Scholastic Testing Services.

Ms. Wittenauer used a variety of media resources in each of the community screening sites. There were articles and announcements in each local newspaper, radio announcements, and public service television five days prior to screening. Letters were sent home with all elementary children in the five school districts.



Professionals were chosen to administer the instrument. "Inservice" was given to the staff by a representative of Scholastic Testing Services. Appointment approach was used, although drop-ins were welcomed.

The screening process went smoothly and both parent and child waited only limited amounts of time. The child proceeded from station to station, while the parent filled out the developmental questionnaire. Upon exiting, the parents of children that exhibited no problems were given immediate feedback of this fact. Letters to the parents of children who displayed some problems were sent in good time along with suggestions for follow-up evaluation and activities to be carried out at home.

The total number of children screened was as follows:

1. Rosedale - 11 children
2. Rockville Elementary - 12 children
3. Central Elementary (Clinton) - 29 children
4. Meadows Elementary School - 39 children.

Summary - Porter County Special Education Coop Screening Program

Porter County Special Education Coop. has been screening preschool children, on referral basis, for several years. In relationship to this program, they were instrumental in organizing an Outreach program with Porter County Schools. Due to time constraints, they were unable to implement the program during the Spring. Their start-up time is targeted for late August, early September, 1979.



Recommendations made by the Program Evaluator

The following are recommendations made by Dr. Jan McCarthy, who evaluated the administration of the total program and the implementation procedures of the Pilot Sites:

1. It is important the LEA's understand that screening instruments are designed to identify children who may have a handicapping condition that could affect their potential for learning and not confuse this process with reading readiness tests that are designed to identify a child's relative preparedness for benefiting from a specific program.
2. Further testing of the screening model should be conducted to study the applicability of the instruments to children who do not speak English as their primary language or who have been raised in different cultures.
3. The screening process should include essential information about the child that the parent could provide (it would be helpful for an examiner to know what areas are of concern to the parent prior to the screening), for example, medical and developmental information that may cause developmental delays.
4. The screening instrument should be acceptable (broad enough to provide an overall picture of the child's functioning) to the specialists who will be performing the follow-up evaluation.
5. Parents should be involved both directly and indirectly in screening process.

Indirectly:

- a. Parents should be told what the screening program consists of and how it fits into the child's school program.
- b. Parents should be told who will perform the screening (as well as when and where), how confidentiality will be respected, and how results will be communicated.



Directly:

- a. Parent representative should be included in Planning Committee.
 - b. Parents should be asked to accompany their child during the screening process. During the actual screening they should be encouraged to sit near the child but out of his/her direct line of vision. If, however, parent observation provokes anxiety in the child, the parent should not observe. Examiners should use discretion in resolving the concern.
 - c. Parents should receive direct feedback promptly.
6. Screening should not be performed in isolation; it should always be performed within the context of a program of subsequent evaluation and intervention. Follow-up is crucial when test results indicate a need.
 7. Screening sites should be in easy access to all segments of community or to transportation when this is not possible.
 8. Screening can be effectively completed by trained paraprofessionals working under the direction of specialists, thus freeing the professional personnel for follow-up evaluation and intervention.
 9. Scheduling of screening should be flexible enough to accommodate the variety of work employment schedule within identified population.
 10. Instruments utilized in screening should be carefully selected. Reliability and validity and the sample population used in establishing these measures should be representative of a broad segment of children.
 11. Parents should be viewed as a valuable source of information regarding their child; and information, via a questionnaire, should be included as part of the screening process.



APPENDIX E

PARENT QUESTIONNAIRE
SAMPLE PARENT LETTER
ADVERTISING

PARENT QUESTIONNAIRE

Date _____

NAME OF CHILD _____ DATE OF BIRTH _____

Where does/will your child go to kindergarten? _____

Does your child attend school now? If so, where? _____

FAMILY

Who is filling out this questionnaire? Father _____ Mother _____ Other _____

Address _____ Phone _____

Father's Name _____ Date of Birth _____

Occupation _____

Education _____

Mother's Name _____ Date of Birth _____

Occupation _____

Education _____

Language(s) other than English regularly spoken at home _____

Do any of your children have difficulty in school? If yes, please give:

Child's Name

Age

Difficulty

SCHOOL HISTORY (include preschool, day care, nursery school, Head Start, etc.)

Has your child attended school before? ____ Yes ____ No

If yes, name the school(s) _____

Dates of attendance: from _____ to _____

Number of days per week: ____ 1 day ____ 2 days ____ 3 days ____ 4 days ____ 5 days

May we contact the school(s) ____ Yes ____ No

CHILD'S MEDICAL HISTORY

Pregnancy

	YES	NO
a. When the mother was pregnant with this child, did she have--		
* excessive weight gain - more than 25 pounds?	_____	_____
* bleeding or spotting?	_____	_____
* high blood pressure?	_____	_____
* measles, mumps, chickenpox?	_____	_____
b. Did she go into labor by herself?	_____	_____
c. Did labor last longer than 24 hours?	_____	_____
d. Method of delivery		
* baby came out by itself		
Was it head first?	_____	_____
or breech (bottom first)?	_____	_____
* forceps delivery	_____	_____
* cesarian delivery	_____	_____



	YES	NO
Birth		
a. Was your child premature?	_____	_____
b. Baby's birth weight _____		
c. Was oxygen required for the baby?	_____	_____
d. Did the baby cry immediately when born?	_____	_____
e. During hospital stay, did the baby have yellow jaundice, rash, blue spells, or convulsions?	_____	_____
f. Did the baby stay longer than the mother in the hospital?	_____	_____
g. Did the baby have difficulty with sucking or crying when first brought to the mother?	_____	_____

Childhood diseases

a. Has your child had --							
	YES	NO		YES	NO		YES NO
measles	_____	_____	german measles	_____	_____	rheumatic fever	_____
mumps	_____	_____	whooping cough	_____	_____	roseola	_____
chickenpox	_____	_____	scarlet fever	_____	_____	polio	_____
b. Does your child have any of the following allergies?							
asthma	_____	_____	eczema	_____	_____	reaction to	
hay fever	_____	_____	wheezing	_____	_____	penicillin	_____
hives	_____	_____	rashes	_____	_____		
c. Has your child ever stayed in a hospital overnight?							

Dates

Reason

_____	_____
_____	_____

FAMILY HISTORY

	YES	NO
a. Do any family members have long-term illnesses or birth defects?	_____	_____
If so, what? _____		
b. Do any other illnesses run in the blood-related family?	_____	_____
If so, what? _____		

CHILD'S HEALTH

The questions below pertain to your child at any time since birth:

Eyes:

Has your child ever had any trouble seeing?

_____	_____
-------	-------

Have your child's eyes ever looked crossed?

_____	_____
-------	-------

Ears:

Has your child ever had frequent ear infections?

_____	_____
-------	-------

Has your child ever had any trouble hearing?

_____	_____
-------	-------

Nose:

Has your child had frequent nose bleeds?

_____	_____
-------	-------

Does your child sneeze frequently or rub his/her nose a lot?

_____	_____
-------	-------

Throat:

Has your child had any trouble swallowing?

_____	_____
-------	-------

Has your child had frequent sore throats or strep throat?

_____	_____
-------	-------

Heart:

Has a heart murmur ever been heard on your child?

_____	_____
-------	-------

Has your child ever had a "blue spell" or swollen ankles or joints?

_____	_____
-------	-------



Lungs:

Has your child ever had

YES NO

pneumonia?

tuberculosis?

or been exposed to tuberculosis?

Has your child ever coughed up blood?

Abdomen:

Has your child ever had frequent vomiting or diarrhea?

yellow jaundice?

frequent stomach pains?

marked weight loss?

blood in bowel movements?

black bowel movements?

Urinary tract:

Does your child have any pain or burning when urinating?

Does your child wet the bed at night?

Extremities:

Has your child ever worn braces or corrective shoes?

Has your child ever had weakness, limp or paralysis of arms or legs?

Has your child ever broken a bone?

Neurological:

Has your child ever had fainting or blackout spells?

frequent headaches?

dizzy spells?

fits or convulsions?

At about what age did your child first --

sit alone

say single words

walk

say sentences

toilet trained

CHILD'S DEVELOPMENT

YES NO DON'T KNOW

1. Can your child --

a. use a spoon and fork to eat without spilling a lot?

b. wash and dry his/her own hands?

c. dress himself/herself?

d. wash and dry his/her own hands?

e. be left alone with a babysitter without a big fuss?

2. Does your child have --

a. problems with eating?

b. problems with sleeping?

3. Does your child still soil his/her pants?

4. Does your child --

a. play successfully with puzzles, blocks and other construction toys without help?

b. hold a pencil properly?

c. write and draw rather than scribble?

d. prefer right hand?

left hand?

both?



	YES	NO	DON'T KNOW
6. Can your child --			
a. ride a tricycle?	_____	_____	_____
b. throw and catch a ball?	_____	_____	_____
7. Does your child --			
a. have many accidents?	_____	_____	_____
b. drop things more often than other children the same age?	_____	_____	_____
c. trip easily?	_____	_____	_____
d. run into things?	_____	_____	_____
e. have trouble with stairs?	_____	_____	_____
8. Is your child --			
a. highly active?	_____	_____	_____
b. very quiet?	_____	_____	_____
c. generally a happy child?	_____	_____	_____
9. Does your child --			
a. cry easily?	_____	_____	_____
b. often have temper tantrums?	_____	_____	_____
10. Does your child --			
a. usually follow directions?	_____	_____	_____
b. have a very short attention span?	_____	_____	_____
11. Is your child --			
a. able to say most sounds correctly?	_____	_____	_____
b. afraid to speak?	_____	_____	_____
c. understandable to a person unfamiliar with your child?	_____	_____	_____
12. Did your child speak later than other children you know?	_____	_____	_____
13. Does your child often repeat sounds or words (stutter or stammer)?	_____	_____	_____
14. Does your child --			
a. turn on the television at a very high volume?	_____	_____	_____
b. say "what, what?" all the time?	_____	_____	_____
c. sit very close to the television screen?	_____	_____	_____
d. bend over and look very closely at pictures or drawings?	_____	_____	_____

IF THERE IS ANYTHING FURTHER YOU WISH TO MENTION ABOUT YOUR CHILD, PLEASE WRITE IT HERE:





EDUCATION
CENTER

Indianapolis Public Schools • 120 East Walnut Street • Indianapolis, Indiana 46204 • (317) 266-4721

*Special Services Division
Special Education*

Dear Parents of _____ Birthdate _____

Your child recently participated in the Preschool Screening Clinic offered by the Indianapolis Public Schools. The primary purposes of the Clinic were three-fold: To provide administrators and teachers with educational information on newly enrolled students; To provide parents with information relative to the development of their children; and To identify those children who might experience difficulty with future educational demands.

During the Clinic, your child was briefly assessed in the areas of Social Concepts, Motor Development, General Concepts, Memory/Problem Solving, Lateral Dominance, and Speech Development (parent report only).

Recommendations made by the Clinic Staff on the basis of this brief contact are checked below:

___ 1. Recommend further evaluation in the following area/areas of development.

___ Social/Emotional

___ Memory/Problem Solving

___ Motor (Gross/Fine)

___ Speech/Language

___ General Concepts

___ 2. No suspected difficulties

___ 3. Emphasis in the following area/areas is recommended during kindergarten/preschool.

___ Social/Emotional

___ Memory/Problem Solving

___ Motor (Gross/Fine)

___ Speech/Language

___ General Concepts

Comments:

Thank you for participating in this Clinic and if you have further questions please contact your school principal/or my office at 266-4721. Confidentiality of obtained information be adhered to per P.L. 94-142 and the Family Educational Rights and Privacy Act of 1974 (Title 45 of the Code of Federal Regulations, Part 99).

Sincerely,

Joseph Leuer,
Project Director
Indiana Preschool Screening Program





EDUCATIONAL SCREENING FOR PRESCHOOL CHILDREN

The Indianapolis Public Schools is sponsoring free preschool clinics from May 21 through June 1st (excluding weekends, May 28 and 29). The screenings, which involve a brief check of each child's eye-hand coordination, language abilities and large motor control, will take place at the IPS elementary schools listed below. Most children develop in these areas at a rate appropriate for their age, but in some cases, this check may indicate more information about the child's abilities should be pursued.

All children who will enter kindergarten in September, 1979 are requested to participate in the clinics. In addition, the program will include younger children, three and four years old, who will start kindergarten in 1980 or 1981.

Sites

School #70
Gym
School #38
Media Center

Address

510 E. 46th St.
2050 Winter Ave.
1115 N. Traub Ave.
1001 E. Palmer St.
5301 Roxbury Rd.
2447 W. 14th St.
4065 Asbury
Earten Bm.

Date

5-21

5-22

5-23

Preschool Clinics Offer Various Tests

Preschoolers can receive a brief check of eye-hand coordination, language abilities and motor control at free clinics sponsored by Indianapolis Public Schools.

School officials urge children entering kindergarten next September to participate in the clinics. The clinics also will be available to 3- and 4-year-olds.

Clinic sites, dates and times will be:

School 38, 2050 Winter; Tuesday; 9-11 a.m. and 1-4 p.m.
School 63, 1115 N. Traub; Wednesday; 9-11 a.m. and 1-4 p.m.
School 18, 1001 E. Palmer; Thursday; 9-11:30 a.m. and 1-4 p.m.
School 106, 5301 Roxbury Road; Friday; 2-5:30 p.m.
School 75, 2447 W. 14th; May 20; 9-11:30 a.m. and 1-4:30 p.m.
School 65, 4065 Asbury; May 31; noon to 4:30 p.m.

IPS Free Preschool Clinics Scheduled

The Indianapolis Public Schools are sponsoring free preschool clinics through June 1 (excluding weekends, May 28 and 29).

For more information about this program, persons can call Joe Leuer at 266-4724.

Following are the schools where clinics are being held:

School 63, 1115 North Traub Avenue, today, 9-11 a.m. and 1-4 p.m.

School 18, 1001 East Palmer Street, tomorrow, 9-11:30 a.m. and 1-4 p.m.

School 106, 5301 Roxbury Road, Friday, 2-5:30 p.m.

School 75, 2447 West 14th Street, next Wednesday, 9-11:30 a.m. and 1-4:30 p.m.

School 65, kindergarten room, 4065 Asbury Street, May 31, 12-4:30 p.m.

Schools 70 and 38 held clinics Monday and yesterday.

The screenings, which involve a brief check of each child's eye-hand coordination, language abilities and large motor control, will take place at some IPS elementary schools which are listed below.

Most children develop in these specified areas at a rate appropriate for their age, but in some cases, this check may indicate that more information about the child's abilities should be pursued.

All children who will enter kindergarten in September, 1979, are requested to participate in the clinics. In addition, the program will include younger children, three and four years old, who will start kindergarten in 1980 or 1981.



Reference Books & Manuals

The following reference books and manuals would be useful additions to local libraries:

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DECLARATION OF THE RIGHTS OF THE CHILD

This year has been proclaimed the "International Year of the Child" by the United Nations General Assembly. It marks the 20th anniversary of the Declaration of the Rights of the Child, and is a world-wide invitation for governments, organizations, media and individuals to "think children", to celebrate the joys they bring and to promote concern for the well-being of children everywhere.

1. THE RIGHT TO AFFECTION, LOVE AND UNDERSTANDING. In 1977, one million cases of child abuse and neglect were reported in the U.S. We must assure an environment that will not damage the health, growth, and development of children.
2. THE RIGHT TO ADEQUATE NUTRITION AND MEDICAL CARE. In the U.S., 17 1/2 million children under the age of 18 exist in dire poverty. 7% - 14% of our young people receive no regular medical care. Some 20 million are not fully protected against prevalent childhood diseases. An estimated 90% of children who need mental health services are not receiving it.
3. THE RIGHT TO FREE EDUCATION. The U.S. has one of the most costly public school systems in the world, yet 13% of 17 yr. olds in school today cannot read or write effectively, and an estimated 25% of children who complete 5th grade will drop out of high school before graduation. The U.S. Commission for IYC feels that education should enable our youth on the basis of equal opportunity, to develop their abilities, individual judgements, sense of moral and social responsibility and to become useful members of society.
4. THE RIGHT TO FULL OPPORTUNITIES FOR PLAY AND RECREATION. Recreation, play and culture are a vital part of childhood, yet they are frequently the targets of school and community budget cuts. More and more children are deprived altogether the option of turning their leisure time into productivity and pleasurable experiences.
5. THE RIGHT TO A NAME AND NATIONALITY. Cultural diversity and equal opportunity must be fostered so that children from various cultures can develop together in a society which is understanding and accepting of all people.
6. THE RIGHT TO SPECIAL CARE, IF HANDICAPPED. 62% of handicapped children from birth to age five are not receiving the services they need. This figure is 42% for ages six to nineteen.
7. THE RIGHT TO BE AMONG THE FIRST TO RECEIVE RELIEF IN TIMES OF DISASTER. Children are our future and our most valuable national resource. Without a doubt, we must see to it that their security is provided for in times of disaster.
8. THE RIGHT TO BE A USEFUL MEMBER OF SOCIETY AND TO DEVELOP INDIVIDUAL ABILITIES. As a human person, a child has the right to the complete development of his or her personality and to make an original contribution to the humanizing of society, and to its development and renewal. The quality of today's world - perhaps even its survival - will be determined by the well-being, safety and development of children today.
9. THE RIGHT TO BE BROUGHT UP IN A SPIRIT OF PEACE AND UNIVERSAL BROTHERHOOD The alienation, prejudice and discrimination suffered by many of our children must be erased so that children now and in the future will grow in a national atmosphere of peace and brotherhood. Our youth are exposed to violence and the portrayal of violence unequalled in the rest of the free world. In Europe, at least one country has banned the production of war toys for their children to avoid the glorification of war.
10. THE RIGHT TO ENJOY THESE RIGHTS, REGARDLESS OF RACE, COLOR, SEX, RELIGION, NATIONAL OR SOCIAL ORIGIN. Every child has a right to live their childhood to the fullest.